Somerset Partnership NHS Foundation Trust

RH5

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5F7	Shepton Mallet Community Hospital	Minor Injury Unit	BA4 4PG
RH5G5	Frome Community hospital	Minor Injury Unit	BA11 2FH
RH5X3	Chard Community Hospital	Minor Injury Unit	TA20 1NF
RH5X2	Burnham-on-Sea War Memorial Hospital	Minor Injury Unit	TA8 1ED
RH5X1	Bridgwater Community Hospital	Minor Injury Unit	TA6 4GU

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation Trust.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

During this inspection, we found that the services had addressed the issues that had caused us to rate safe, effective and well led as requires improvement following the September 2015 inspection. Urgent care services were now meeting Regulations 15 and 17 of the Health and Social Care Act (regulated Activities) Regulations 2014. The ratings for urgent care services in caring and responsive remain the same as in 2015 (good). Safe, effective and well-led have all changed from requires improvement to good.

We rated urgent care services for adults as good because:

- Staff understood their responsibilities to raise concerns and recorded safety incidents, concerns and near misses. We saw that when things went wrong, there were thorough and robust reviews or investigations carried out.
- There were systems and practices in place that were essential to protect people from abuse and avoidable harm and staff were aware of these.
- The design, maintenance and use of facilities and premises kept people safe. All examination rooms we inspected were, clean and well equipped. The maintenance and appropriate use of equipment kept people safe. There were reliable systems in place to prevent and protect people from a healthcare-associated infection related to cleanliness of buildings. All minor injury units we visited were clean, tidy and well maintained.
- Staffing levels and skill mix were planned and reviewed to support safe practice.
- Patients' needs were assessed and care and treatment was able to be delivered in line with legislation, national standards and evidence-based guidance. Emergency nurse practitioners had access to paper and online National Institute of Health and Care Excellence (NICE) guidelines
- Information about the outcomes of patients' care and treatment was collected and monitored. During 2015/16 there were 210 unplanned re-attendances within 7 days of treatment, for 158 patients. This was less than 1% of the annual minor injury unit (MIU) attendance rate. Most patients who used the service were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example over 97% of patients who were treated did not return for further treatment. The average waiting time for patients in one of the trust's MIUs was only 40 minutes and considerably less than the national average of 63 minutes and around 99.8% of patients waited under 4 hours for treatment.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was liaison with local emergency departments, with social services and general practitioners. There was a working relationship with ambulance service providers.
- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment in the minor injury units (MIUs). We saw that staff took the time to interact with patients who used the service and those close to them in a respectful and considerate manner.
- Staff respected patients' dignity and privacy. For example, they closed doors when they left clinic rooms and drew curtains where a curtain was provided in the MIU to provide privacy (Shepton Mallet, Chard).
- Patients who used the service and those close to them were involved as partners in their care. Staff we observed communicated well with patients and those close to them so that they understood their care, treatment and condition. Staff made sure that people who used the service and those close to them were able to find further information or ask questions about their care and treatment. Staff we observed assessing and treating patients demonstrated an understanding of and respected patient's personal, cultural, social and religious needs, and took them into account.
- Services were planned and delivered to meet the needs of patients who used the service. Information about the needs of the local population were used to inform how services were planned and delivered.
- Staff understood where people might have different needs, and adjustments may be needed to the care and treatment they were given
- There was a comprehensive local strategy to deliver good quality care and to develop the service to be able

Summary of findings

to respond to any changes in the needs of the local community in respect of urgent care. The trust had developed a mission statement and a set of values with staff who worked for the organisation.

- The governance framework for minor injury units (MIUs) ensured that responsibilities were clear and that quality, and risks were understood and managed. The risk register was effective for identifying, recording and managing risks, issues and mitigating actions.
- Leaders of the MIUs had the skills, knowledge, experience and capacity needed to lead and manage the service. Leaders were visible and approachable. The service manager and nurse consultant worked as emergency nurse practitioners for a proportion of their time.
- The culture centred on the needs and experience of patients, who used the service, and those close to them. Patients and those close to them who used the service and the public were engaged and involved. Patients' views and experiences were gathered. Most staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Staff attended regular best practice groups and operational group meetings with the nurse consultant and the service manager.
- The service had continuously improved in a range of areas since the previous inspection.

However:

- Not all staff were up-to-date with mandatory training, including safeguarding.
- The monitoring of systems in place to prevent cross infection from practitioners was not reliable. We saw a small number of staff who did not wash their hands immediately before and after every episode of direct patient contact or care or for the length of time recommend by trust policy. We saw some staff not bare below the elbow.
- Audits of infection prevention and control for MIU completed by community hospital staff did not include handwashing technique. The trust had completed only two separate audits in two of the seven minor injury units for handwashing in 2015/16.
- Record keeping quality within minor injury units was variable.
- The arrangements for managing medicines did not always keep people safe. We saw that there were some out of date drugs in two MIUs and a number of the PGDs we reviewed were out of date. These were approved documents permitting authorised members of staff to supply or use prescription-only medicines.
- Arrangements for gaining and recording consent were not clear. The consent checklist in MIU included the phrase: Fraser competent when it should refer only to Fraser guidelines and Gillick competences. Fraser guidelines are only suitable for contraceptive advice while Gillick competent refers to the capacity to make specific decisions
- One MIU reception desk was not suitable for wheelchair users to communicate easily with reception staff due to a printer situated on it.
- Patients could not be seen directly by staff in some MIU waiting areas.

Summary of findings

Background to the service

Somerset Partnership NHS Foundation Trust was created on 1 May 2008. On 1 August 2011 the trust acquired Somerset Community Health and is now the principal provider of community health, mental health and learning disabilities services in Somerset.

The minor injury units run by Somerset Partnership NHS Foundation Trust (the trust) are located at seven community hospitals across Somerset: Frome, Glastonbury (also known as West Mendip), Shepton Mallet, Chard, Bridgwater, Minehead and Burnham-On-Sea. The minor injury units (MIU) are run by a service manager, clinically led by a nurse consultant and staffed by emergency nurse practitioners, paramedic qualified staff, nurses, healthcare assistants and receptionists The receptionists were managed by community hospital staff and not MIU. Emergency nurse practitioners are senior registered nurses specialising in advanced emergency and urgent care. They have extensive post-registration education and clinical experience and are registered as independent prescribers.

X-ray services, including radiographers, were provided by local acute hospital trusts.

The trust minor injury units provided urgent unplanned patient care for all non-life threatening clinical conditions. They treated and provided care for the majority of patients who presented at the units and then discharged them home. They referred the remaining patients (2.6%) to other services for other care as needed, for example orthopaedic clinics, general practitioners or acute services.

Minor injury unit staff aimed to stitch cuts, remove foreign bodies from ears and noses, remove splinters, dress minor wounds, cuts and grazes, apply plaster casts, provide screening and treatment for chlamydia, treat sprains and strains, minor broken bones, minor burns and scalds, minor head injuries, insect and animal bites, minor eye injuries and other minor injuries. They also assessed and treated minor illnesses such as sore throats.

The trust minor injury units saw approximately 100,000 patients in 2015/16. This was a total increase of approximately 10,000 patients seen per year overall since 2012. 97.4% of patients were assessed, treated and discharged without the need for referral elsewhere.

When the CQC inspected the trust in September 2015, we found that the trust had breached regulations. We issued the trust with requirement notices for urgent care services. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

• Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

• Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Our inspection team

Our inspection team was led by:

Team Leader: Gary Risdale, Inspection Manager (Mental Health), Care Quality Commission

The MIU inspection team included two inspectors and two specialist nursing advisors.

Summary of findings

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to their urgent care services since our last comprehensive inspection of the trust in September 2015.

When we last inspected the trust in September 2015, we rated urgent care services as requires improvement overall.

We rated the core service as requires improvement for safe, effective and well-led and good for caring and responsive.

Following the September 2015 inspection, we told the trust to make the following actions to improve urgent care services:

- Strengthen governance arrangements to ensure that maintenance logs for equipment used on and with patients are up to date and show where equipment is not maintained.
- Strengthen governance arrangements to ensure that all risks to service delivery are outlined in the service's local risk register, and where appropriate are included on the corporate risk register. Also ensure that there are clear management plans to address risks and that these management plans are regularly reviewed.
- Strengthen supervision or one to one arrangements to ensure that all staff receive one-to-one management and clinical supervision in line with trust policy.
- Ensure that the minor injury unit service is compliant with statutory and mandatory training.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 15 Safety and suitability of premises

Regulation 17 Good governance.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The regulated activities we inspected were:

• Diagnostic and screening procedures

• Nursing care

• Treatment of disease, disorder or injury

As part of this inspection the four members of the inspection team inspected five of the seven minor injury units - Shepton Mallet Community Hospital, Frome Community hospital, Chard Community Hospital, Burnham-On-Sea War Memorial Hospital, and Bridgwater Community Hospital

The inspection team spoke with six patients (five adults and one child). We spoke with 26 staff, including three lead emergency nurse practitioners, twelve emergency nurse practitioners (ENP) and developing ENPs, a nurse consultant and service manager, four nurses and health care assistants. We also spoke with five receptionists. We observed approximately seven episodes of care. We met with five people who were carers or relatives. We also reviewed care or treatment records of 38 people who used the service.

We did not carry out an unannounced visit.

Summary of findings

What people who use the provider say

We received 120 comments cards from patients who had used the service during the inspection period They were from Chard, Shepton Mallett, Minehead and West Mendip.

All were positive about the treatment received.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve:

- Ensure training and processes for implementing the Mental Capacity Act 2005 and establishing and recording consent are adequate.

Action the service SHOULD take to improve:

- Ensure adequate systems are in place to ensure Patient Group Directives used in minor injury units (MIU) are in date.
- Ensure adequate systems are in place for checking medicines in MIUs are in date and stored appropriately.
- Ensure all staff in MIU comply with handwashing best practice and strengthen the processes to monitor handwashing technique.
- Ensure all patients in MIUs are assessed for pain and that the assessment and treatment of pain is recorded in all cases.
- Ensure appropriate safeguarding assessments for adults and children are recorded in patient records in MIUs.
- Ensure all staff are up-to-date with mandatory training, including safeguarding.
- Consider having a consistent process for identifying and sharing risk alerts on patients' notes across all MIUs.
- Consider carrying out a training needs analysis for 'sieve and treat' training and other MIU specific tasks for reception staff.
- Consider how patient confidentiality in MIUs can be improved.
- Review the visibility of patients in all MIU waiting areas.

Somerset Partnership NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rerated safe as good because:

- The service had addressed the issues that had caused us to rate safe as requires improvement following the September 2015 inspection.
- Staff understood their responsibilities to raise concerns informally and formally where appropriate. They recorded safety incidents, concerns and near misses.
- Safety performance, based on internal and external information we reviewed, showed the service saw approximately 100,000 patients per year with one death. The service had received assurance from the Coroner and from review of the incident that the death was not related to assessment, care or treatment by MIU staff.
- 92% of patients received an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival.
- We saw that when things went wrong, there were thorough and robust reviews or investigations carried out. All relevant staff and people who used the services were involved in the review or investigation.
- There were systems and practices in place that were essential to protect people from abuse and avoidable harm and staff were aware of these. All the minor injury units provided adult and children safeguarding training and there were child protection flow charts to follow if staff felt they needed to raise any concerns. We saw that most staff had followed safeguarding processes and many had completed referrals.
- The design, maintenance and use of facilities and premises kept people safe. All examination rooms we inspected were clean and well equipped.
- The maintenance and appropriate use of equipment kept people safe.
- There were reliable systems in place to prevent and protect people from a healthcare-associated infection related to cleanliness of buildings. All minor injury units we visited were clean, tidy and well maintained.
- Staffing levels and skill mix were planned and reviewed to support safe practice.
- Records showed all staff using Patient Group Directions (PGDs) were trained in their use. These were approved documents permitting authorised members of staff to supply or use prescription-only medicines with certain groups of patients within approved guidelines.
- Some aspects of record keeping and clinical practice had improved from previous years, for example if the patient was under 16 safeguarding process must be considered (91% improved from 86%), written and verbal advice given to all patients (96% improved from

75%). The conclusions of the audit included plans and actions for overall record keeping and practice which included summaries for individual practitioners learning.

However:

- Not all staff were up-to-date with mandatory training, including safeguarding.
- The monitoring of systems in place to prevent cross infection from practitioners was not reliable. We saw a small number of staff who did not wash their hands immediately before and after every episode of direct patient contact or care or for the length of time recommend by trust policy. We saw staff not bare below the elbow. Audits of infection prevention and control for MIU completed by community hospital staff did not include handwashing technique. The trust had completed only two separate audits in two of the seven minor injury units for handwashing.
- Record keeping within minor injury units was variable. An audit of record keeping and clinical practice in August 2016 identified areas for improvement. These included: patients over 65 with a falls risk assessment (33%), all adults attending MIU should have vulnerable adults assessment completed (49%).
- The arrangements for managing medicines did not always keep people safe. We saw there were some out of date drugs in two MIU's, although these were disposed of immediately when we informed the senior nurse on duty.
- A number of PGDs were out of date. We reported this to the trust and they took action to ensure that PGDs were brought up to date.
- MIU reception staff did not receive awareness training for the 'sieve and treat' process used in MIU.

Detailed findings

Incident reporting, learning and improvement

- Safety performance, based on internal and external information we reviewed, showed the service saw approximately 100,000 patients per year with one death. The death had been recorded following attendance at a minor injury unit (MIU). The service had received assurance from the Coroner and from review of the incident that the death was not related to assessment, care or treatment by MIU staff. The outcome was shared with the staff member involved.
- There were no never events in relation to care or treatment in MIUs. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff understood their responsibilities to raise concerns formally and informally where appropriate. They recorded safety incidents, concerns and near misses. Staff we spoke with said that whenever an incident happened they would try to resolve any issues locally with involvement of senior staff (senior emergency nurse practitioner and when necessary service manager or nurse consultant) and record as an incident through the electronic incident reporting system. We saw evidence of staff incident reporting through the electronic reporting system. We also saw evidence of staff investigating issues and identifying learning relating to investigation of incidents.
- The incident reports we saw reflected a range of issues reported including a death, faulty equipment and 'near miss'. We saw evidence that shared learning from incidents happened at best practice meeting groups and quarterly continuing professional development staff meetings.
- Staff we spoke with said there were occasions where issues that should be reported via the electronic incident reporting system did not always get addressed in the way they would like. We reviewed incident reporting process and reports and spoke with senior managers and staff who managed risk and incident reporting. We could not identify any occurrences where a serious incident or repeat incidents, that were less serious but due to frequency were cause for concern, had not been dealt with appropriately by service leads and senior emergency nurse practitioners (ENPs) or the trust. Electronic incidents were reviewed by a number of different managers so themes would be identified by the risk team who were located outside of the MIU management.
- Between 1 January 2016 and 31 January 2017 MIU's recorded 280 incidents (less than 1% of annual attendance) for the time period. The trust reported 40 'near miss' incidents for MIU's: nine from Bridgwater, eight from Frome, seven from Glastonbury (West Mendip), six from Minehead, five from Burnham-On-Sea, three from Shepton Mallet and two from Chard. All were

reviewed by a range of staff including nurse consultant, senior emergency nurse practitioners and service manager. All 40 near misses were resolved as near miss – incident prevented.
  - 33 were recorded as no injury or harm occurred
  - Two were recorded as minor injury - first aid treatment required
  - Five were recorded as short term harm – patient required further treatment/procedure. Of these, three required liaison with a local ambulance trust to understand how they could be prevented, one other was linked to ambulance response but not yet fully investigated, and one resulted in the MIU being removed from a directory of service so that patients were not directed inappropriately to the MIU.
  - One of the near miss incidents described delays to process because of a lack of training of staff members, which may have affected patient safety. As a result, additional training was provided.
  - One of the near miss incidents described increased demand being placed on MIU from the out of hour's service which was being resolved by GPs and senior managers.
- Lessons were learned and improvements made when things went wrong. Most staff we spoke with said they got feedback from raising incidents and generally saw change as a result.
- We saw evidence of learning shared both for MIUs, for the provider more widely and with other organisations in a range of minutes of meetings. Feedback was also shared with other service partners for example the ambulance service, at regular meetings.
- We saw that when things went wrong, there were thorough and robust reviews or investigations carried out. All relevant staff and people who used the services were involved in the review or investigation.
- Incident reviews were shared with all units at monthly Best Practice Group meetings for MIU.

Duty of Candour

- People who used the minor injury units were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. From a review of incidents and complaints, we saw an example of when a notification about an incident had been given, support provided and an apology given in line with the duty of candour regulation.
- Some staff we spoke with demonstrated knowledge of when to apply duty of candour and staff knew they were required to be open and honest, and apologise to people when things went wrong.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm that falls into defined thresholds. We saw evidence that this had occurred.

Safeguarding

- Not all systems and practices in place protected people from abuse and avoidable harm. Safeguarding training rates for MIU as a service were 93% on 31 January 2017, just below the trust target of 95%. All MIU nursing staff had, as a minimum, level two child protection training. All minor injury unit staff who dealt directly with children were being trained to level three. Staff training rates for all safeguarding was as follows:

- Bridgwater 88.4%
- Frome, 95.4%,
- Minehead 94.8%
- West Mendip (Glastonbury) and Shepton Mallet 94.2%.

- The safeguarding training rates were broken down as follows:

- adults level two – 83.3% for Bridgwater, and 100% for all other MIUs
- adults level three was between 14.3% and 62.5%
- children's level two was 100%
- children's level three was between 37.5% and 100%.

- The low rates in some areas were due to recent recruitment and unplanned absence. The trust had only recently started to offer level three children's safeguarding training, which is why rates were low. Staff moved between MIU so the figures reflected a staff member's base hospital only.
- All the minor injury units provided flow charts to follow if staff felt they needed to raise any concerns.
- Staff we spoke with understood their responsibilities but did not adhere to safeguarding policies and procedures at all times. Following our previous inspection in September 2015 the trust were asked to take steps to ensure there was objective evidence available in

patients' records of all adults and children receiving appropriate safeguarding assessments. However, the audit of clinical practice and record keeping within minor injury units and a review of patients' records during inspection showed us this did not always happen. The trust MIU standard was that all adults should have the vulnerable adults assessment complete. The audit in August 2016 demonstrated that only 49% of adults were identified as having had a vulnerable adult assessment completed a drop from 54% in the previous year. The trust's standard was 80% and above.

- Staff in MIU's described several examples of potential safeguarding cases and how they had acted on their concerns. We saw evidence of this in incident reporting and complaint investigations.
- Data from the trust supported that referrals were being made. Nine safeguarding adult referrals and 21 safeguarding children referrals were made to the local authority in 2015/16 by MIUs. We saw referral outcomes and action plans that were collated by the trust.
- Staff in the MIU's had access to a senior nurse and doctor's opinion 24 hours a day, via telephone, for child welfare issues if needed.
- Contact information and what to do to raise a concern when abuse was suspected to an adult or a child was available in all minor injury units, on the walls in public and staff areas and on stickers on telephones. We saw some evidence in patient records of consideration given to safeguarding for children. Practitioners were compliant with standard five of the trust audit (patients under 16 who had a child protection flow chart completed - 91% - trust target 80%-100%).
- All children seen in MIU's had letters sent to GP's, school nurses and health visitors, which helped to maintain up to date information regarding health and social care for children who may come into contact with other professionals.

Medicines

- The arrangements for managing medicines and medical gases did not always keep people safe. In most MIU's staff ensured that non-controlled resuscitation medicines (including intravenous fluids) were stored ready for use. We saw lorazepam 4mg stored in an unlocked medicine storage refrigerator in Burnham-on-Sea MIU. The refrigerator was unlocked and was brought to the attention of staff on duty who locked it.
- We also saw out of date intravenous lorazepam 4mg, stored in a double locked controlled drugs (CD) cupboard. There was no in date lorazepam in the CD cupboard at Bridgwater MIU meaning in an emergency there was none immediately available. The out of date drugs were disposed of immediately when we told the senior nurse on duty.
- MIU's worked under a system called patient group directions (PGDs). These were approved documents permitting authorised members of staff to supply or use prescription-only medicines with certain groups of patients within approved guidelines. We looked at a number of the electronic master PGDs available in the trust and we saw some were not current and therefore were not approved, as required, by appropriate senior staff. We reported this to the trust and they took action to ensure PGDs were all up to date be establishing a new review date. Records showed all staff using PGDs were trained in their use.
- MIUs employed a number of nursing staff who were qualified to prescribe and administer medicines (called non-medical prescribers). These nurses were able to administer medicines or write prescriptions for patients to take to a dispensing chemist. They were also able to issue as a 'to take away' medication from stocks held in the units. This was done against the nurse practitioners prescription on the medication administration record. The prescription pads (FP10) were stored securely. We also saw good practice regarding issuing of prescriptions where the drug issued was linked to the patient record.
- All medicines refrigerators we checked during inspection were operating within the correct temperature range. There were records of regular temperature checks.
- The MIU staff followed the trust resuscitation policy and the medical emergencies management policy (non-cardiac) December 2013. Medicines stocks for resuscitation were sufficient and secured in tamper-evident boxes or packaging.

Environment and equipment

- Resuscitation equipment was available and fit for purpose. It was adequately stocked and there was evidence of regular checks.
- The design, maintenance and use of facilities and premises kept people safe. All examination rooms we inspected were private, clean and well equipped. The

examination room in Shepton Mallet was divided by a curtain from other parts of the minor injury units, but it was far enough away from the public waiting area to be private.

- Most reception areas and waiting rooms provided good visibility to enable reception staff to observe patients. However, in Chard MIU receptionist cover was not provided at all times of opening. This meant patients were not visible at all times. The Burnham-On-Sea reception area seating was partially obscured by a vending machine so staff could not see all patients at all times.
- Minor injury units had a variety of equipment to ensure safety to staff and others, including cameras that viewed car parks and entrance areas.
- Staff in MIU's were adhering to the trust lone working policy. Personal alarms were recorded on the local risk register as a mitigating factor for lone working, risk assessments had been completed and shared with ENP leads. Staff were aware of actions to take to minimise risk and used professional discretion in deciding if they needed to wear the alarm.
- All medical gases were present either through a piped supply or in cylinders. There were sufficient quantities of cylinders in the units.
- Following our previous inspection the trust were required to strengthen governance arrangements in the urgent care service to ensure that maintenance logs for equipment used on and with patients were accurate. We saw evidence this was happening and premises and equipment used by the service provider were properly maintained.
- Medical devices were managed on behalf of the trust by a local acute hospital. Equipment we checked was in date with servicing intervals. We saw equipment maintenance logs that assured us equipment had been maintained appropriately to keep people safe. We saw evidence the MIUs were compliant with servicing and return of items for servicing, we received evidence that supported safe practice.
- The arrangements for managing waste and clinical specimens kept people safe. We saw appropriate segregation, storage, labelling, handling, and disposal of waste. Sharps bins for the disposal of used needles and glass medicine containers were labelled, were not overfilled and there were enough for use.

Quality of records

- The service ensured that availability of patient medical records was achieved by using paper and electronic systems.
- Most patients' individual care records were written and managed in a way that kept people safe. We reviewed 38 patient records and saw that most were completed in line with trust guidance and consistent with the most recent audit (5 August 2016).
- The trust audit of Clinical Practice and Record Keeping within Minor Injury Units was carried out annually and reviewed 13 documentation standards and clinical decision making processes. This enabled the service to give assurance to the trust of the maintenance of good clinical standards and enable work to be focussed on areas for improvement.
- The August 2016 audit reviewed 555 patient records and highlighted a number of areas of good practice for record keeping as well as further improvement that were needed. Overall there had been a clear improvement in record keeping over the five years 2011-2016
- Most risk assessments were completed appropriately. Areas of good practice included: recording of whether patients under 16 were accompanied by an adult or not (95%) and if care and treatment was Bolitho compliant - which meant the trust considered the risk assessment and treatment provided by the practitioner was rational (99.8%).
- The following results were considered to be safe practice and so were rated green: all patients attending MIU having a fully completed assessment recorded (90%), patients under 16 who had a child protection flow chart completed (91%), and all drug names written in capital letters(78%).
- However, areas of record keeping the trust identified as needing improvement included: patients over 65 with a falls risk assessment (33%), and standard seven in clinical practice set by MIU 'all adults attending having a vulnerable adults assessment' completed (49%) - a worse position from the previous two years (60% and 54%).
- The conclusions of the audit were that "…there still seems to be some difficulties with ensuring vulnerable adults and fall checks are made". Additionally, pain scoring and weighing of babies under one year old were

noted as key areas for improvement. We saw plans and actions for overall record keeping and practice, which included summaries for individual practitioners' learning.
- Records were stored securely.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare-associated infection related to the cleanliness of the environment. All MIU's we visited were clean, tidy and well maintained. Most buildings were relatively new. We saw evidence of testing that ensured water supplies were free from Legionella and cleaning rotas. For the infection control audits minor injury units were audited separately from the hospital sites. The audits did not cover handwashing technique. They included hand hygiene facilities, personal protective equipment, ward environment, decontamination of equipment and clinic room, cleaning and disinfection and linen management. We saw audits for Chard, Frome and Glastonbury (West Mendip). We were not sent information for Minehead, Bridgwater or Burnham-on-Sea.
- There were hand-wash sinks that were appropriately sited, paper towels, bins and hand gel dispensers that were working.
- We saw staff wash their hands before assessing patients. However, the monitoring of the systems in place to prevent and protect people from a healthcare-associated infection from practitioners was not reliable. We saw a small number of staff who were not complaint with NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. These staff were also not compliant with trust policy which stated "Somerset Partnership NHS Foundation Trust has adopted a zero tolerance approach to non-compliance with …Hand Hygiene policy ". We observed some practitioners at Burnham-On-Sea, Bridgwater and Chard MIUs carrying out assessment or treatment. Some staff did not comply with the trust's 'bare below the elbow' policy and wore a wristwatch. Other staff did not wash their hands immediately after touching a patient having carried out an assessment. They did not then wash their hands before using equipment that would be used for other patient assessments or touching patient paper records. One occurrence was during the assessment of a patient who had been diagnosed with an infection.
- Some staff washed their hands for significantly less than 30 seconds, the minimum time recommended by trust hand hygiene policy. When we requested evidence of handwashing 'roadshows', where staff handwashing technique assessments occurred, we were told the trust's infection prevention and control (IPC) team provided update training as requested or as indicated post audit. The trust had completed handwashing audits at two of the seven MIUs.
- All community hospitals in which MIUs were located had equipment to test handwashing technique, with IPC link practitioners trained in its use. The trust said it had devolved responsibility of this as a routine tool to local areas and as such central records were not held. We were told local records were recorded within the electronic staff record, but we did not review these.
- The infection prevention and control audit for Glastonbury (West Mendip) MIU dated October 2016 scored 92% overall:
  - hand hygiene facilities - 71%
  - personal protective equipment (PPE) - 100%
  - ward environment - 78%
  - decontamination of equipment and clinic room - 84%
  - cleaning and disinfection - 95%
  - linen management - 80%
- The infection prevention and control audit for Chard MIU dated August 2016 scored 100% overall:
  - hand hygiene facilities - 100%
  - personal protective equipment - 100%
  - ward environment - 86%
  - decontamination of equipment and clinic room - 94%
  - cleaning and disinfection - (figures were not supplied)
  - linen management - 100%
- We saw evidence that two handwashing audits had been carried out in Bridgwater MIU scoring 100% in May and November 2016 for all clinical staff.

Mandatory training

- Staff had received mandatory training in the safety systems, processes and practices for MIU's in some areas. Following our previous inspection the trust were

required to ensure the minor injury unit staff were compliant with statutory and mandatory training. We saw evidence this had occurred in June 2016. The current compliance rates for mandatory training were low, but consistent with a 'rolling year'. The trust target for mandatory training compliance was 95% of all staff required to complete the topic. Performance was as follows:

- Basic Life Support – 90.1%
- Fire training – 91.7%
- Moving and Handling (patient level 2) – 91.5%
- We did not check all reception staff training records. Those we did were up to date. Staff working on reception were not managed by MIU staff but by the hospital site manager where they were located.

Assessing and responding to patient risk

- Following our previous inspection the trust were required to review the time that a patient was first seen by a registered healthcare practitioner after arrival in the department and ensure that there were systems in place that followed national recommendations for urgent care settings. This had been completed. The trust did not have complete data for the number of attendances seen within 15 minutes due to recent changes in electronic recording. Where they did have complete records, 92% of attendances (41,595) were assessed within 15 minutes.
- Following our previous inspection in September 2015 the trust were required to develop a triage policy that set out how initial patient assessments should be carried out, who should carry out the assessments and within what timescale. The trust had developed a 'sieve and treat' process policy document which was consistent with the Royal College of Emergency medicines 'unscheduled care facilities', (minimum requirements for units which see the less seriously ill or injured) 2009 and The Royal College of Emergency Medicine, Triage Position Statement 2011.
- The initial management of patients' was clear receptionists did not triage or complete initial assessments. The 'sieve and treat' process included guidelines for receptionists to follow if patients presented with one or more of the following symptoms: chest pain, shortness of breath/unable to speak in sentences, acute headache, bleeding, acute abdominal pain, pain where pain relief was needed, overdose of drugs, signs of stroke, floppy, pale children, unwell children with a rash, or any reason causing concern. If any of these symptoms were present the receptionist would immediately inform the emergency nurse practitioner (ENP).
- Patients were registered by a receptionist who used an electronic system which also showed on a separate screen at the nurse's station or desk. The emergency nurse practitioners prioritised patients before deciding what actions to take next, and what order in which patients would be seen. We saw this process in practise.
- We were told the guidelines should be displayed at the MIU reception desks next to the screens and visible at all times. We saw one MIU where the process was not visible and in another an ENP said they had not seen the process.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Most emergency nurse practitioners and nurses we spoke with were confident that 'sieve and treat' and the processes to identify any change in a patient's condition were keeping patients safe. Staff used the recommended physiological observations outlined in trust policy to monitor patients. They were also clear about when to call for assistance and who from. Observations ranged from pulse, blood pressure, oxygen saturation, pupil size and reaction, and other clinical signs. They also included patient at risk scoring, paediatric Glasgow coma scale and professional judgement.
- We requested data from the trust about the number of administrative or reception staff in last year who had received training or awareness sessions regarding the guidelines or the 'sieve and treat' process. We were told the trust did not provide triage training or 'sieve and treat' education for any of the trust's administrative and reception staff. It did however provide them with customer care training and prevention and management of violence and aggression level one module, which focussed on communication and elements of customer care.
- The service had also implemented the National Early Warning Scoring (NEWS) system supported by National Institute for Health and Care Excellence (NICE). This system was recognised nationally for accurately predicting and monitoring deterioration. MIU staff used the NEWS criteria and a sepsis form to help them

identify patient deterioration and possible or actual sepsis. The MIU documentation included the NEWS chart. The process for assessing patients for deterioration in MIUs was included in the physiological observations guidelines.

- Children's vital signs were able to be monitored and emergency nurse practitioners acted on their experience, professional advice from other minor injury unit staff or acute settings, and followed relevant NICE guidelines, for example CG160: Feverish Illness in Children.
- Where necessary, emergency nurse practitioners dialled 999 when a patient required an emergency ambulance or spoke with the nearest relevant emergency department team for advice regarding assessment, diagnosis and treatment of a patient. Cardiology advice was available from an external provider.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed to support safe practice.
- The minor injury service used the Royal College of Emergency Medicine (RCEM) workforce guidance to determine clinician staffing levels. The RCEM guidance suggests that one full time equivalent (FTE) Emergency Nurse Practitioner will see on average 3,000 patients each year. Staffing levels met this recommendation but had minimal capacity to flex to cover busy periods and staff breaks.
- All units generally had a minimum of one ENP with one trained nurse and often more than one ENP on duty. However at times of sudden sickness or shortages there were occasions when they were on with an HCA. Shift handovers were verbal between staff and were sufficient to keep people safe.
- The use of bank, agency and locum staff was reducing. Whenever the MIU's needed to use agency or bank staff they used a preferred agency which had the job description for the emergency nurse practitioner role. This meant the agency was able to supply appropriately skilled staff.
- If an emergency nurse practitioner was due to work and was not available the issue was escalated to senior managers who would agree and source bank or agency cover. If cover was not available the unit would not open and patients would have to attend minor injury units in other areas or call NHS 111. Between February and August 2016 there had been 19 closures due to staff shortages (sometimes for as little as three hours, and on one occasion for a complete night shift (11pm to 7.30am). Information was visible for patients to see where else they could attend if the MIU was closed. Units had occasionally opened with one staff member due to patients already being in waiting areas and short notice absence of minor injury unit staff. This was recorded in incident reports. There were no occurrences of harm to patients when this happened.
- At several MIUs staff told us that taking breaks was difficult. They also spoke about situations where they had worked over their allocated shift. This was due to not being able to turn anyone away close to the end of their shift and when demand on an MIU was high. This could happen at peak holiday times and could be more difficult at the holiday destinations, such as Minehead, Burnham-on-Sea and Glastonbury (West Mendip). Staff found it difficult to take a break as it would mean leaving people waiting for longer. Some staff also told us they felt there should be additional nurse resource to 'stream or triage' when units got busy. We spoke with the service manager and the nurse consultant about the issues. They acknowledged it was difficult but staff had been told they should take breaks and this had been recorded in minutes of a team meeting. The nurse consultant acknowledged this had caused some anxiety for emergency nurse practitioners who were concerned for the waiting time for patients but said that it was up to individual clinicians to manage their breaks. Nurses had raised these issues using the incident reporting system. Staffing had been reviewed and the issues and mitigating actions were recorded on the risk register.
- As of January 2017 staff sickness rates were: Bridgwater 7.6%, Chard 4.2%, Frome 11.9%, Minehead 6.4%, Shepton Mallet 2.4%.
- Staff turnover rates were: Bridgwater 43.5%, Chard 10.5%, Frome 47.6%, Minehead 12.1%, Shepton Mallet 30%. .
- Staff would escalate staffing concerns to the service manager, nurse consultant or lead ENP for that unit if there was increasing pressure on staffing. Managers would then assess risk, including using the electronic system to see what types of illnesses or injuries were presenting at all the MIUs. They would then move staff as appropriate to provide support for the unit.
- The trust's comprehensive option appraisal for the minor injury unit service (November 2016) recorded current staffing numbers, and what would be needed to

Good

Are services safe?

sustain the service considering the anticipated increase in demand based on the last four years' attendance figures. In the proposal for succession planning for the provision of minor injuries service across Somerset (March 2015), minor injury units were noted as having had an increase in clinical activity of 5.5% in the last three years. In the November 2016 appraisal it reported a 3% increase every year for the last 12 years. We saw plans to manage the increase.

- Staff recruitment and retention had been a significant issue for the trust's MIUs over the past 18 months. Primarily these issues had related to emergency nurse practitioners (ENPs). ENPs were a valuable resource and the trust had to compete locally with emergency medicine departments, the ambulance service and general practice to recruit and retain staff. Other employers were providing higher levels of pay, more sociable hours and less intense workloads.

Medical staffing

- The MIU service was an emergency nurse practitioner led service.
- Medical support and governance was provided to the countywide service by two local acute trusts. They supplied support through eight training sessions each per year for staff from all MIUs. Additionally, there was access to 24 hour telephone advice and up to two shifts per month per unit there were medical staff on site.

Managing anticipated risks

- Staff were able to describe what they would do to respond to any potential disruption to providing a service, for example in periods of adverse weather they would attend the next nearest MIU site.
- Seasonal fluctuations in demand were managed by planning rotas in advance to anticipate increase in demand. Local events, such as a large music festival, had its own medical cover and there was little impact recorded on MIU.
- Risk assessment and impact assessments had been carried out before suggesting changes to the service, including staffing, to meet future demand.
- If demand increased at an MIU this could be monitored from other MIUs by senior managers who could respond by redeploying staff where available.
- There were appropriate security arrangements to keep staff and others safe and protected from violence.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents and minor injury units had been involved in business continuity and major incidents processes.
- Table top exercises had been held in all community hospitals to test local plans for business continuity management (BCM), lockdown and evacuation and shelter. Local plans had been developed for all community hospitals. MIU staff had been included in these exercises wherever an MIU was co-located in a community hospital. The trust's incident response plan and BCM, Lockdown and Evacuation policies were available to staff on the trust's intranet.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rerated effective as good because:

- The service had addressed the issues that had caused us to rate effective as requires improvement following the September 2015 inspection.
- Patients' needs were assessed and care and treatment was delivered in line with legislation, national standards and evidence-based guidance.
- Most adult patients and all children who were in pain received pain relief in a timely manner.
- Information about the outcomes of patients' care and treatment was collected and monitored.
- During 2015/16 there were 210 unplanned re-attendances within 7 days of treatment, for 158 patients. This was less than 1% of the annual minor injury unit (MIU) attendance rate.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There were arrangements for supporting and managing staff and identifying learning needs and completing revalidation.
- The nurse consultant and the service manager had completed clinical shifts at a number of the trust's minor injury units, which supported their skill retention, provided support to and gave opportunity for staff to speak with managers.
- Staff had opportunity to request formal one-to-one meetings as part of the trust's supervision policy.
- The MIUs were involved in a wider network of support for urgent care providers. This included emergency department consultants.
- There was liaison with local emergency departments, social services and general practitioners. There was a working relationship with ambulance service providers.
- All staff were able to access patient details and previous attendances on the electronic system. There were also systems in place to recall notes when a patient re-attended the minor injury unit to complete treatment or for reassessment.

However

- Arrangements for gaining and recording consent under the Mental Capacity Act (2005) were not clear and staff had variable understanding of the legislation and processes.

Details findings

Evidence-based care and treatment

- Clinical guidance had been assessed by the trust as compliant or partially compliant as appropriate against evidence-based guidelines. These included clinical guidelines for the Management of Transient Loss of Consciousness in Adults, infection control, osteoporosis fragility fracture, headaches, ectopic pregnancy and miscarriage, feverish Illness in children, falls, head injury, atrial fibrillation, dyspepsia and gastro oesophageal reflux disease, and pneumonia.
- We also saw evidence of compliance, or partial compliance, with National Institute of Health and Care Excellence (NICE) guidelines NG9 Bronchiolitis in children, NG10 Violence and aggression, NG15 Antimicrobial stewardship, NG46 Controlled drugs and NG51 Sepsis.
- Patients' needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance. Emergency nurse practitioners (ENPs) had access to paper and online NICE guidelines. They also had access to trust guidance and patient group directives (PGDs). However, some PGDs we reviewed were out of date or did not follow current guidelines, for example treating urinary tract infections. When we told the trust they reviewed the PGDs immediately and began the process of ensuring all were up to date and current.
- Audits of recognition and treatment of sepsis had not been undertaken to date in MIUs. There was no current plan for an MIU audit. The nurse consultant monitored the resuscitation logs in each MIU for trends including sepsis and shared information within the trust.

Good

Are services effective?

Pain relief

- Patients did not always have their pain assessed and managed in a timely manner. Two patients we spoke with said they had had to wait to receive pain relief.
- Emergency nurse practitioners used a pain score where they considered if pain relief was relevant in line with the trust's physiological observations policy. For example, a pain score might not be recorded if an adult presented with a cut finger (although the presence of pain would be recorded as free text on the patient record).
- An audit of clinical practice and record keeping within MIUs was carried out in August 2016. The standard for pain management was that 'the patients' pain score must be a) recorded and b) analgesia expedited' (given promptly). The audit showed only 54.4% (234 of 430) patients who were eligible for pain assessment had a pain score recorded. This was below the trust target of 80% and was slightly lower than the previous year (55%). The trust were unable to establish from the audit if the remaining 196 (45.6%) patients did or did not have a pain assessment, so the assumption was that they did not.
- It was not possible to tell from the audit when patients had pain assessed and recorded and appropriate timely pain relief given. This was because not every patient had an assessment recorded and of those who did it was unclear in a number of cases why pain relief was not given.
- The Royal College of Emergency Medicine Management of Pain in Children (revised July 2013) requires all children to be offered pain relief within 20 minutes of arrival and those in severe pain to be reassessed every hour. All children we saw who were experiencing pain were managed well and carers of children we spoke with spoke highly of the treatment.

Technology and telemedicine

- Equipment was used to enhance the delivery of effective care. Staff had access to remote consultant-led electrocardiogram (ECG) analysis and interpretation that provided quick and accurate diagnosis for patients. This supported emergency nurse practitioners to make decisions based on accurate clinical information.
- Staff also had access to digital X-rays and the ability to send them to acute hospitals for second opinions or advice.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored. The outcomes were monitored through local audit. The audit of clinical practice and record keeping, was completed 2016 and results were shared within the trust and with individual practitioners. The clinical practice and record keeping audit reviewed 13 standards, including appropriate assessment completion (for example pain assessment) and the practitioner's reasoning for providing treatment. This meant the nurse consultant, service manager and emergency nurse practitioner (ENP) leads could provide support to staff to improve or maintain practice.
- The nurse consultant and service manager had also audited MIU compliance against 11 clinical guidance and five national institute of clinical and health excellence (NICE) guidelines to assure the trust that MIU practice was compliant with national guidelines and supported good outcomes for patients. Ten clinical guidance standards were compliant and one was partially compliant, which required an antimicrobial prescribing policy to be amended. Clinical guidelines included: CG109 Management of Transient Loss of Consciousness in Adults, CG154 Ectopic pregnancy and miscarriage, CG160 Feverish Illness in Children, CG176 Head injury and CG191 Pneumonia. The MIUs were compliant with four of the five NICE Guidelines: NG9 Bronchiolitis in children NG10 Violence and aggression NG46 Controlled drugs NG51 Sepsis. There was only partial compliance with NG15 Antimicrobial stewardship. An antimicrobial stewardship group had started in February 2017 to work with other organisations to improve the practice and prescribing of medicines in, for example, sepsis and urinary tract infections.
- Staff engaged in regular audit feedback, for example audits for controlled drug management, at best practice groups and other team meetings to learn about changes or actions needed.
- Numbers of patients attending with 'sepsis' were not audited. However, the nurse consultant was involved in a programme with the antimicrobial stewardship group to develop guidelines for appropriate antibiotics to give depending on the source of the sepsis.

Good

Are services effective?

- During 2015/16 there were 210 unplanned re-attendances within seven days of treatment, for 158 patients. This was less than 1% of the annual MIU attendances.
- All patients we saw that attended the MIUs were reassessed by emergency nurse practitioners before their discharge from the department. This was in line with best practice to ensure best possible outcomes and to support other nurses and health care assistants to deliver optimum care.
- All episodes of care where deterioration had been identified (regardless of the cause) were recorded in the local MIU resuscitation log. These were reviewed regularly by the nurse consultant. Any specific learning was fed back to staff. This included post incident debrief sessions where required.

Competent staff

- The service manager and nurse consultant worked with staff on clinical shifts and relied on lead or senior emergency nurse practitioners to monitor staff compliance and maintenance of standards and best practice. They also used continuing professional development meetings to support development.
- There were arrangements for supporting and managing staff. These included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. Staff who had not completed induction were not allowed to work independently until they had done so.
- All 60 trained nurses working in the MIUs were in date with revalidation.
- Staff had appropriate training to meet their learning needs and the needs of the service. They were encouraged and given opportunities to develop. Training included Advance Life Support (ALS) for the 38 ENP's (26 had completed the four yearly recertification). All six developing ENP's were on course to complete ALS. Seven eligible ENP's were on non-medical prescribing courses funded by the trust.
- In 2015 the nurse consultant told us of plans for all emergency nurse practitioners to complete minor injury and minor illness in children training. The funding from Health Education South West had been agreed at the end of 2014 and the first staff started the training in January 2015. This supported the development of knowledge in assessing and treating children beyond the skill set attained from the emergency nurse practitioner course. Eighteen of the 38 staff eligible had completed the course at the time of the inspection.
- Following our inspection in September 2015 the trust was required to strengthen clinical supervision and one-to-one arrangements in the urgent care service. This had not been fully implemented but interim plans were in place. This was not yet complete due to time taken to recruit staff and review the supervision policy.
- We were told management and clinical supervision for the emergency nurse practitioners was not carried out on a scheduled one-to-one basis. This was because the lead emergency nurse practitioners worked across a number of sites as well as managing a clinical caseload. The nurse consultant explained all leads had an open door policy and worked clinically with all staff within the departments and had held sessions on site as and when appropriate. Staff we spoke with confirmed this was the case.
- In February 2017 the staffing hours of the service had been changed, in line with the review proposal approved by the trust Board in November 2016, to provide improved support for staff. This would enable a plan to ensure staff one-to-one meetings were diarised in advance, on a six-weekly programme of clinical supervision. This was initially planned to take the form of peer review groups, which were due to commence by the end of March 2017. Additionally, a new clinical supervision policy had been formulated and was planned to be implemented in March 2017. We saw evidence of regular one–to-one meetings with the lead ENP's and the service manager confirmed that they had not received any request for one-to one meetings for ENPs. The nurse consultant had carried out formal one-to-one meetings with lead and other staff in relation to feedback and learning from complaints.
- The service also had ongoing 'dynamic' supervision and reflection on a day-to-day basis. These took place during work sessions and involved staff discussing and consulting with colleagues and peers. This was in addition to the arrangements that were in place for peer review clinical supervision sessions with the local acute trusts, and clinical governance sessions within the trust.
- Staff rotated through different minor injuries units to ensure consistency in their competence. This was because some minor injury units were busier than others and there was opportunity to

reinforce competence in busier environments. This helped support staff in their continuing professional development and allowed for best practice to be shared.
- The nurse consultant and the service manager had completed clinical shifts at a number of the trust's minor injury units. This supported their skill retention, provided support and gave opportunity for staff to speak with managers.
- All staff had to complete image retrieval medical assessment training before they were competent to order X-rays.
- Most staff felt it was easy to attend taught sessions at quarterly continuing professional development meetings. However, some found it hard to attend the taught sessions due to covering some shifts when staff were absent at short notice, and had to rebook training.

Multidisciplinary working

- Staff worked together to assess and plan ongoing care and treatment in a timely way.
- The MIUs were involved in a wider network of support for urgent care providers. This included local emergency department consultants. The MIUs were also part of continuing professional development programmes from acute trusts outside of Somerset.
- There were good examples of multidisciplinary working between specialities, including onsite therapists and radiographers.
- We saw evidence of good examples of external multidisciplinary working. This included during transfers between sites, admissions to wards, liaison with emergency departments, links with external electrocardiogram (ECG) providers and with social services and general practitioners. There was also a good working relationship with ambulance service providers. Emergency nurse practitioners told us that ambulance staff would contact the minor injury unit before attending to discuss if a patient was appropriate to be treated there. Sometimes emergency nurse practitioners assessed the patient with ambulance staff before making a decision where best to treat the patient. Where there were issues we saw that managers and other staff had raised them appropriately and were engaging with other providers to find solutions. For example, delayed transfers or inappropriate referrals from GP. We saw evidence of minor injury unit senior staff meeting with ambulance service staff to resolve process issues, which reduced delay or inappropriate use of both services.

Referral, transfer, discharge and transition

- MIU staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services. We saw evidence of patients with a range of injuries being referred to orthopaedic clinics and dressing clinics. We also saw patients being enabled to self-refer for musculoskeletal clinics.
- Data showed 97.4% of patients' had their needs met in the MIUs. The remaining 2.6% of patients attending were referred to an outpatient clinic in another trust (people visiting the area), transferred to another health care provider (for example to general practice), or admitted to an acute hospital.

Access to information

- The systems the trust used to manage information about people who used services supported staff to deliver effective care and treatment.
- All staff were able to access patient details and previous attendances on an electronic patient record system. There were systems in place to recall notes when a patient re-attended an MIU to complete treatment or for reassessment.
- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, case notes and test results.
- Shepton Mallet and Frome MIUs identified current alerts, such as medicines allergies, on transferring details from the electronic system to paper notes by writing a large red capital 'A' on the paper record. This then drew the attention of the emergency nurse practitioner (ENP) to review the current alert. We did not see this practice at other MIUs.
- Paper records used by ENPs were scanned into the electronic record.
- It was possible to identify repeat attendances that children may have made at other minor injury units and emergency departments in the county, which supported identification of safeguarding issues.

Good

Are services effective?

- When a child attended an MIU, information was shared with their general practitioners, health visitors and school nurses.
- Staff were able to access NICE guidelines and trust policies online to support clinical decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. We found some staff understood how to obtain consent and the requirements of legislation and guidance relating to mental capacity, while others did not have the same level of understanding. The Mental Capacity Act (2005) and consent were included in safeguarding training and most staff were up-to-date with this.
- Mental capacity for making decisions for adults was determined during verbal interaction between the emergency nurse practitioner and patient (as well as with any carer as appropriate). Staff in the minor injury units were able to demonstrate establishing the assumption of capacity as set out in Section 1 of the Mental Capacity Act (2005).
- We saw examples of consent being sought from patients, including children and their parents. This demonstrated some staff were acting in accordance with the Mental Capacity Act (2005).
- Arrangements for recording consent were not clear. The 'capacity to give consent checklist' in MIUs included the term: 'Fraser competent'. Fraser guidelines are only for contraceptive advice. The correct standard should be Gillick competence, which refers to a child's capacity to make specific decisions.
- The consent checklist was not clear and could also be interpreted that consent could be gained from a carer of an adult who had decision making capacity. This was not in line with the Mental Capacity Act (2005) and best interests decision making.
- When we spoke with the nurse consultant they confirmed the form applied to both adults and children and there was a need for further clarity on what practice actually happened in relation to the Mental Capacity Act (2005).

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated the urgent care services as **good** for caring because:

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment in the minor injury units (MIUs). We saw staff took the time to interact with patients who used the service and those close to them in a respectful and considerate manner.
- Patients' dignity and privacy was respected by staff. Clinic doors were kept closed and curtains were drawn where clinic rooms were not provided.
- Feedback from patients both before and during our inspection was overwhelmingly positive,
- All patients who used the service and those close to them were involved as partners in their care. Staff we observed communicated well with patients and those close to them so they understood their care, treatment and condition.
- Staff made sure that people who used the service and those close to them were able to find further information or ask questions about their care and treatment.
- Staff we observed assessing and treating patients respected and demonstrated an understanding of patients' personal, cultural, social and religious needs, and took them into account.
- Emotional support and information was provided to those close to people who used the services, including carers and dependants. For example, we saw several parents and their children supported. One parent described staff as "really good" and told us they felt they could ask questions.
- Patients we saw, who used the service, were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. Over 97% of patients who attended were treated and did not return for further treatment. Patients and carers we were able to speak with left the MIU satisfied with their treatment.
- When people were experiencing emotional distress staff responded in a compassionate, timely and appropriate way. Staff we observed showed an encouraging, sensitive and supportive attitude to patients and those close to them who used the service.
- Almost all patients we saw who used the service were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example, over 97% of patients who were treated did not return for further treatment. Patients and carers we were able to speak with left the MIUs satisfied with their treatment.
- Staff at Burnham-on-Sea MIU reception sometimes used a radio for background noise to support confidential discussions taking place. The treatment area at Chard MIU was small and at times two patients could be in the area, if one was waiting for an ambulance. However, staff did their best to ensure privacy during consultations.

Detailed findings

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment in MIUs. We saw staff took the time to interact with patients who used the service and those close to them in a respectful and considerate manner.
- Patients' dignity and privacy was respected by staff. Doors to clinic rooms were kept closed and curtains were used to provide privacy in some MIUs where clinic rooms were not available. Reception staff recorded patients' details in a confidential manner and most reception areas were suitable for carrying out conversations that would not be overheard. However, staff at Burnham-on-Sea MIU reception told us they sometimes used a radio for background noise to support confidential discussions. The treatment area at Chard MIU was small and at times two patients could be in the area, if one was waiting for an ambulance. However, staff did their best to ensure privacy during consultations.
- Feedback from patients during our inspection visits was all positive. We received 120 comments cards about the service. Comments included: "thoughtful staff", "thoroughly reassuring", "100% fantastic (nurses)", "helpful, friendly and very attentive reception staff", and

Good

Are services caring?

"service overall excellent". Feedback gathered by the trust for MIUs as a whole was overwhelmingly positive. We spoke with several patients about their care and no one complained about the service or the staff.

- Through observation and discussion with patients we found that almost all of the time they and their carers were given sufficient time for explanations of the assessments made, treatment carried out and outcomes expected. We heard emergency nurse practitioners (ENPs) speak in a confident, calm and kind manner. ENPs gave clear advice and we observed they were caring in manner, as were other staff. However, we did observe a small number of interactions where staff were perceived by specialist advisors as not giving time for patients to ask questions at the end of their consultation or treatment.

Understanding and involvement of patients and those close to them

- All patients who used the service and those close to them were involved as partners in their care. Most staff we observed communicated well with patients and those close to them so they understood their care, treatment and condition.
- Staff recognised when people who used services and those close to them needed additional support to help them understand and be involved in their care and treatment and enable them to access it. This included accessing interpreters for specialist advice for patients.
- Patients who used MIUs were empowered and supported to manage their own health, care and wellbeing to maximise their independence. We saw evidence of an episode of care where the emergency nurse practitioner had explained antibiotics were not appropriate, despite repeat requests to provide them by a patient. This often difficult conversation was managed professionally by the emergency nurse practitioner. The ENP based their management on the assessment they had carried out which showed the treatment would not have been clinically appropriate.
- Patients who used the service and those close to them were able to find further information or ask questions about their care and treatment.
- Staff we observed assessing and treating patients respected and demonstrated an understanding of patients' personal, cultural, social and religious needs, and took them into account. We saw one treatment where a standard approach would have been to give a recognised mainstream pain relief. After assessment and discussion the patient's wishes were respected and advice was given about the patient using their own remedy, in conjunction with the one suggested by the practitioner.

Emotional support

- Patients who used the service and those close to them received the support they needed to cope emotionally with their care, treatment or condition.
- Staff demonstrated they understood the impact that a person's care, treatment or condition might have on their wellbeing and on those close to them.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Emotional support and information was provided to those close to people who used the services, including carers and dependants. For example, we saw several parents and their children supported. One parent described staff as "really good" and told us they felt they could ask questions.
- Patients we saw, who used the service, were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. Over 97% of patients who attended were treated and did not return for further treatment. Patients and carers we were able to speak with left the MIU satisfied with their treatment.
- When people were experiencing emotional distress staff responded in a compassionate, timely and appropriate way. Staff we observed showed an encouraging, sensitive and supportive attitude to patients and those close to them who used the service.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated the responsiveness of the urgent care services as good because:

- Services were planned and delivered to meet the needs of patients who used the service. Information about the needs of the local population was used to inform how services were planned and delivered.
- Performance figures demonstrated that 97% of patients had their needs met by the minor injuries units (MIUs).
- 95% of patients were assessed within 60 minutes of arrival and 92% were assessed within 15 minutes of arrival.
- The vast majority of patients waited under four hours for treatment
- The service had compared itself to other units across the country. The two nearest acute trusts saw between 55,000 and 65,000 patients each every year. The number of patients seen by the trust's MIUs was approximately 100,000 each year and 97% of these patients were not referred on to another agency.
- Staff understood where people might have different needs, and adjustments may be needed to the care and treatment they were given.
- There was information available in MIUs about how to make complaints. We saw that patients who used the service knew how to make a complaint or raise concerns, and they were encouraged to do so.

However:

- There was variation in availability of X-ray and patient experience depending on which unit was visited, the day of the week and the time of the day. X-ray facilities were not provided by the trust.
- During 2015/16 there were 397 adults and 160 children aged under 18 who left MIUs without being seen. Bridgwater and Glastonbury (West Mendip) had the highest figures for leaving MIU without being seen.

Detailed findings

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of patients who used the service. Information about the needs of the local population was used to inform how services were planned and delivered. We saw a comprehensive analysis of the service and a plan of future needs. This outlined what was needed to ensure the service met ongoing and future demand. It was benchmarked against national statistics for minor injury units (MIUs) or urgent care centres.
- Overall the facilities and premises were appropriate for the services that were being planned and delivered. The minor injury units (MIUs) we visited had adequate seating and space in reception and waiting areas.
- Services provided reflected the needs of the population and they ensured flexibility, choice and continuity of care. Some MIUs were not wholly compatible with wheelchair use, for example Burnham-On-Sea reception was partially obstructed by electrical equipment. Some MIUs had poor parking facilities but all were accessible by bus.
- Performance figures demonstrated that 97% of patients had their needs met by the minor injuries unit.
- Some areas covered by the trust were more highly populated in the summer months due to the influx of tourists. To manage increased patient demand there were extended opening hours during this period. Staff had raised some concerns when patient demand exceeded staff capacity (we saw this in incidents reported). The trust had responded by revising staffing and recruiting.
- The general issue of any longer term, sustained increase in demand on the service was not on the local or divisional risk register. However, reference to ambulance delays and problems of travel associated with arrangements for a local festival was. We did not see any planning for how older buildings or other unmet needs were identified and used to inform how services were planned and developed.

Meeting people's individual needs

- Staff understood where people might have different needs, and adjustments may be needed to the care and treatment they were given.
- Translation services were available by telephone and a range of leaflets were available in different languages, for example Polish, Portuguese and Turkish.

Good

Are services responsive to people's needs?

- Patients were supported to seek help at the right service. This included support for mental health and sexual health concerns.
- However, the electronic patient record system used in MIUs did not automatically transfer information regarding ethnicity, religion or other alerts from the main electronic patient record.
- We saw staff arrange hot and cold drinks for patients and carers. Some staff asked patients if they wanted anything to drink if they had been waiting rather than wait to be asked.
- Some units had vending machines for patients to buy food and drink.

Access and flow

- During 2015/16 the trust had moved between three different patient administration systems as a part of improvement programmes. As a result there were periods when some MIU sites were recording a minimum amount of information about numbers attending. This meant the trust were unable to provide complete data for the number of attendances seen within 60 minutes. Where the trust did have data, 95% of patients (43,044) attendances were assessed within 60 minutes of arrival.
- Where the records were complete, 92% of attendances (41,595) were assessed within 15 minutes of arrival at MIU sites.
- During 2015/16 there were 397 adults and 160 children aged under 18 who left MIUs without being seen. Due to the move between data collection systems the trust recognised the data may be incomplete. Data provided by the trust indicated that 425 adults and 172 children left MIU overall. Bridgwater and West Mendip had the highest figures for leaving without being seen. Patients chose to leave the unit before being seen for a variety of reasons, including wait times. However, the percentage of 'do not waits' for the trust as a whole was 1.5 - 2%, which was better than the national standard of 5%.
- The service had compared itself to other hospital units across the country. The two nearest units were at acute hospital locations and they saw between 55,000 and 65,000 patients each every year. The number of patients seen by the trust's MIUs was approximately 100,000 each year and 97% of these patients were not referred on to another agency.
- The senior managers for MIU and the trust acknowledged the increasing demand that primary care was having on MIU and that the increased demand and acuity was likely to continue. This was also reflected nationally.
- The Emergency Care Benchmarking Summary 2015 and its subsequent updates demonstrated how the trust's minor injury services' performance compared with similar NHS organisations providing minor injury and community urgent care services (referred to as 'level 3 A&E'). The trust had the largest number of patients attending MIUs compared to other level three urgent care unit providers.
- The number of nursing staff per 100,000 patient attendances at the trust's MIUs showed that the trust employed 62 whole time equivalent nurses per 100,000 patients seen. This equated to 1,577 MIU attendances per trust whole time equivalent emergency nurse practitioner (ENP) compared with the national average of 1,415. This was in the upper 25% of the MIUs nationally. The vast majority of patients (99.8%) waited under four hours for treatment.
- The key findings from the benchmarking analysis was that the MIU's performance on every indicator was better than the majority of its peers: they treated more people, with fewer resources, at a lower cost, and still saw patients in less time than most comparable units. Bridgwater saw the highest number of patients at 487 per week average, the lowest was Burnham-On-Sea with 123.
- Minehead MIU was open 24-hours a day, seven days a week. Frome and West Mendip MIUs were open 8am until 9pm with X-ray facilities between 9am and 5pm Monday to Friday.
- Bridgwater was open 8am until 9pm, with X-ray facilities 9am to 5pm Monday to Friday. Burnham-On-Sea was open 10am until 6pm between April and October, and between 11am and 3pm between November and March. There was no access to X-ray facilities at any time. Chard opened between 9am and 9pm, X-rays were available three days per week at variable days and times.
- X-ray services were not provided by the trust.

Learning from complaints and concerns

- There was information available in minor injury units to support patients and carers to make complaints. We saw that patients who used the service knew how to make a complaint or raise concerns, and they were

Good

Are services responsive to people's needs?

encouraged to do so. The trust provided information about complaints before the inspection. There were 13 complaints each year for the past three years. There were 16 formal complaints between January and December 2016. Of those, two were not upheld, 11 partially upheld, two fully upheld and one with an unknown outcome due to still in process. Most of these complaints related to clinical care for example a diagnosis given which subsequently was found to be incorrect, such as a sprain when it was a fracture or the attitude of staff members when treating or communicating with a patient or carer.

- Complaints were handled effectively and confidentially, with a regular update for the complainant and a formal record was kept. The trust provided evidence that the outcome of complaints had been explained to people.
- Where patients and those close to them had concerns and complaints we saw that they were listened and responded to and their concerns used to improve the quality of care. The learning from complaints was incorporated into future practice. We saw evidence of learning from complaints and concerns at continuing professional development meetings where staff went through each complaint to discuss issues, findings and responses. Some learning was recorded in outcomes of incidents from incident reporting and team and departmental meeting minutes.
- Learning was shared with other organisations where appropriate for example to support improvement in working with local ambulance trusts.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We re-rated well-led as good because:

- The service had addressed the issues that had caused us to rate safe as requires improvement following the September 2015 inspection.
- There was a comprehensive local strategy to deliver good quality care and to develop the service to be able to respond to any changes in the needs of the local community in respect of urgent care.
- The trust had developed a mission statement and a set of values with staff to represent the ambition of the trust as Somerset's main provider of community and mental health services
- The governance framework for minor injury units (MIUs) ensured responsibilities were clear and that quality, and risks were understood and managed. We saw incident reporting data and risk assessments.
- The risk register was effective for identifying, recording and managing risks, issues and mitigating actions.
- Leaders of the MIUs had the skills, knowledge, experience and capacity needed to lead and manage the service.
- Leaders were visible and approachable. The chief executive had visited the MIUs and had met with emergency nurse practitioners (ENPs). The service manager and nurse consultant worked as ENPs for a proportion of their time.
- The culture in MIU centred on the needs and experience of patients, who used the service, and those close to them.
- Patients and those close to them who used the service and the public were engaged and involved. Patients' views and experiences were gathered through NHS choices, general feedback, the NHS Friends and Family Test and a local survey.
- Most staff felt actively engaged and their views were reflected in the planning and delivery of services and in shaping the culture. Staff attended regular best practice groups and operational group meetings with the nurse consultant and the service manager.
- The service had continuously improved in a range of areas since the previous inspection
- Staff demonstrated working in partnership and providing quality care.
- The trust used a variety of forms of patient feedback to review patient experience, including where patients have not waited for treatment. These included the NHS Friends and Family Test, complaints/patient advice and liaison service (PALS) and local patient surveys.

However:

- The values were not always clearly displayed in MIUs and staff were not always able to say what they were.
- Some staff felt they were not involved in development of the trust vision.

Detailed findings

Vision and strategy for this service

- There was a comprehensive trust strategy which recorded challenges, such as increase in demand and staff choosing to work for other providers. The strategy described how the trust would deliver good quality care and develop the service to be able to respond to any changes in the needs of the community in relation to urgent care. The strategy document, which described options to develop the service, was submitted to commissioners in March 2015 and revised for submission again in November 2016.
- The trust had developed a mission statement and a set of values with staff to represent the ambition of the trust as Somerset's main provider of community and mental health services.
- The mission, or what it was the organisation was there to do, was 'caring for you in the heart of the community'. Minor injury units, because of their location, enabled the trust to deliver care that was personal to the individual close to where most people lived. The trust mission was also that staff who delivered those services were to be caring and compassionate. Staff worked in a caring and compassionate way. Staff were not always able to describe the mission.
- There was a clear set of values, with quality and safety as priorities, embodied in 'working together', 'everyone counts' and 'making a difference'. The values were not

always clearly displayed in MIUs and were not always clearly articulated by staff. Staff were able to speak about principles, such as working in partnership and providing quality care.

- The vision for the organisation was a statement of where the trust wanted to be and what the trust should look like in the 'near future'. The vision for the trust was: "[the trust] will be the leading provider of community-based health and social care." We saw evidence the trust was working towards this for MIUs. There was also work ongoing with other organisations to understand what the provision of health care and MIUs would look like in the near future

Governance, risk management and quality measurement

- The governance framework for MIUs ensured responsibilities were clear and that quality and risks were understood and managed. We saw appropriate incident reporting, data collection, risk assessments and management of risk through the risk register.
- There was an effective governance framework to support the delivery of the strategy and good quality care. Staff reported issues and incidents to the service manager and nurse consultant. They then reported to the divisional lead and director of nursing who reported to the trust board representative. Investigation of incidents took place and staff received feedback after reporting an incident.
- Quality and performance were measured and understood by service and trust leaders. This was through audit of clinical practice and performance figures.
- Performance was understood. However, following recent organisational and systems change some data was unavailable. Data that was collected by the trust to date showed increase in demand year on year and similar performance to previous years. The trust had responded with recruitment of more staff and changes in rotas.
- Staff at all levels in the trust we spoke with were clear about their roles and they understood what they were accountable for.
- Following our last inspection in September 2015 the trust were required to strengthen governance arrangements to ensure all risks to service delivery were outlined in the urgent care local risk register and where appropriate were also included in the corporate risk register. The requirement was also to ensure there were clear management plans to address risks and that these were regularly reviewed. We found this was in place, including an improved risk register with mitigating actions embedded. The risk register was effective for identifying, recording and managing risks, issues and mitigating actions. The risk register identified the service manager and senior emergency nurse practitioner as leads in the description of the risks.
- There was alignment between the recorded risks and what staff said was 'on their worry list'. For example, staff 'worry lists' included not enough staff for them to feel comfortable in taking breaks while patients waited for treatment and not enough staff to manage spikes in demand (these issues had been raised as incidents)
- The supervision policy was under review and recent staff changes were made to include provision for managers and leads to give more opportunity for one-to- one meetings where practitioners wanted it. Temporary measures had been put in place to support staff better. Most staff we spoke with said the arrangements worked. A few still felt that time did not allow them to engage with one- to- one meetings or group supervision as much as they wanted. However the new staffing system had only started 7 February 2017.
- We saw evidence of some local audits completed in relation to minor injury units, for example an audit of clinical practice and record keeping, which was completed annually. Analysis and conclusions were minimal in this audit and not all learning points were clearly identified. We saw some evidence of learning shared from audits in team and departmental meeting minutes, which included feverish illness in children audit and falls audit reports.

Leadership of service

- We spoke with the MIU leadership team, including the director of nursing (who was also the head of patient safety), head of operations, divisional leads, senior managers and nurse consultant. All understood the challenges to provision of good quality care in MIU. The leaders could identify the main risks, challenges and opportunities. They were able to talk about the actions taken and actions still needed in future to address risk and challenges.
- The nurse consultant had identified actions needed with the service manager in a paper for the clinical

commissioning group in November 2016. These included addressing issues identified with service capacity, skill level and local, regional and national changes that would affect MIUs.

- Leaders were visible and approachable. The chief executive had visited MIUs and had met with emergency nurse practitioners (ENPs). The service manager and nurse consultant worked as ENPs for a proportion of their time, which kept their skills current and enabled staff to speak with them. Most staff we spoke with said they had either worked with them or had the opportunity to speak about practice and service development issues with them. The service manager and nurse consultant acknowledged they were unable to visit all minor injury units as regularly as they would like.
- MIU staff we spoke with were positive about senior ENPs as leaders. Staff said leaders encouraged appreciative, supportive relationships among staff.
- Succession planning was in place for when the service manager was due to retire in March 2017.

Culture within the service

- The culture we saw centred on the needs and experience of patients who used services, and those close to them.
- We observed strong supportive teams who were able to deal with whatever arrived at a minor injury unit and staff who knew to call for additional assistance when needed. We also experienced a culture that encouraged candour, openness and honesty. For example, staff at all levels shared their concerns during inspection and what might be needed to resolve issues. Appropriate issues were on the risk register and risks were discussed at team meetings.
- Overall the culture was one of openness and transparency and this was described by staff as a means to promote good quality care. Despite issues raised about breaks and the demand on the service at times, most staff we spoke with described feeling valued.
- Staff and teams worked collaboratively, to share responsibility to deliver good quality care.
- We saw, where needed, the service had taken action to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority.

Public engagement

- The trust used the NHS Friends and Family Test to collect feedback from patients.
- The service used a range of other methods to gain feedback and views of patients. There was positive feedback, such as compliments about patient care and short waiting times, and some negative comments mainly about length of waiting time. These were shared in team meetings to support continuing good practice and to identify areas where efficiency could be improved.
- Views were gathered through NHS choices, general feedback and a local survey. During September 2016 staff in the trust carried out a survey exploring the reasons why patients chose to attend the MIU as opposed other healthcare providers. The survey was undertaken in all MIUs and 1,933 questionnaires were returned. When asked why a patient had attended a given unit the response was often a report of the injury or illness they were experiencing rather than feeding back about the unit or staff. The key emerging themes of the feedback were as follows.

- 68% of patients attended the unit without contacting any other service
- 20% of patients attended the MIU on the advice of their GP surgery – it is not clear the extent of which this was medically informed advice appropriate to the presenting condition, or what proportion was advice due to capacity of surgery and available appointments.
- 10% of patients stated they attended the unit due to them not being able to get a GP's appointment.

- Senior managers and leads had also reviewed this information to support discussions and creation of action plans with other health and social care providers, including GPs. This was planned to support improvement in patient experience, to increase cost effectiveness and consolidate partnership working in the West Somerset locality.

Staff engagement

- Most staff we spoke with felt actively engaged and their views were reflected in the planning and delivery of services and in shaping the culture. Staff attended regular best practice groups and operational group meetings with the nurse consultant and the service manager.

Good

Are services well-led?

- Leaders and staff understood the value of staff raising concerns. Staff used the electronic incident reporting system to raise concerns and managers of the service had engaged with them about issues raised. Appropriate action had been taken as a result of concerns raised.
- We spoke with a few members of staff who felt their concerns over 'triage', safety and breaks had not been addressed. When we spoke with senior managers, the service manager and consultant it was clear action had been taken and feedback from staff had been accompanied by change. However, the pace of the change had been delayed due to recruitment so some staff may still have felt their views were not being considered.

Innovation, improvement and sustainability

- The service had continuously improved in a range of areas since our previous inspection, including recruitment and development of staff. All but one action from our previous inspection had been addressed. The action outstanding was ensuring clinical supervision options were available for all staff according to trust policy. However, recent recruitment, a rota change in February 2017 and a new policy in March 2017 were designed to ensure this action was addressed.
- Developments to services and planned efficiency changes had been considered given the impact on quality and sustainability. The issues were assessed and monitored in a paper 'Minor Injuries Services: Option for achieving sustainability' (November 2016). The consultant nurse for MIUs described the potential future development of the MIUs. One strategy was to move to an urgent care model, managing an increase in complexity by providing a service which bridged the gap between minor injuries units and emergency departments. The trust had a clear vision outlined for responding to future commissioning intentions that mirrored national plans.
- To further support improved recruitment and retention a range of activities had been undertaken, including the expansion of an ENP training programme in partnership with neighbouring universities. The trust were developing six of their own staff as ENP trainees. They started training in 2016 and were planned to be in place in 2017. The programme of new ENP trainees ensured succession planning and the existing ENP training programme was planned to be expanded. This would mean the programme could support other providers of urgent care in the region.
- A partnership had been developed between Somerset's NHS trusts and local education providers to train one of the first waves of nursing associates. The new nursing associate role was planned to support registered nurses across the county. We spoke with one healthcare assistant in MIU who spoke highly of this initiative and was looking forward to developing in the role.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11** 11(1) Care and treatment of service users must only be provided with the consent of the relevant person. • Arrangements for recording consent were not clear. The 'capacity to give consent checklist' in MIUs included the term: 'Fraser competent'. Fraser guidelines are only for contraceptive advice. The correct standard should be Gillick competence, which refers to a child's capacity to make specific decisions. • The consent checklist was not clear and could also be interpreted that consent could be gained from a carer of an adult who had decision making capacity. This was not in line with the Mental Capacity Act (2005) and best interests decision making.